

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09535

Reg. Dist. No. 186

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Hartford</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u> c. LENGTH OF STAY IN 1b <u>-</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, T</u> d. STREET ADDRESS <u>R.D.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>John</u> First <u>J.</u> Middle <u>A</u> Last <u>Abraham</u>		<b>4. DATE OF DEATH</b> <u>September 10 1957</u> Month <u>September</u> Day <u>10</u> Year <u>1957</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-5-1877</u>
<b>9. AGE</b> (In years last birthday) <u>80</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>	<b>IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>owner</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Lewis W. Abrahams</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Bartlett</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <u>John J. Abrahams Jr.</u> Address <u>Port Deposit, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture femur</u> DUE TO <u>900.0</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last, DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>9-8-57</u> Hour <u>2</u> p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	<b>20f. (City or town)</b> <u>Port Deposit</u> (County) <u>Cecil</u> (State) <u>Md.</u>
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>Gerald C Palmer</u> M.D.		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <u>Bel Air</u>	
<b>EXAMINER'S NAME (Type)</b> <u>Gerald C Palmer</u> M.D.		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <u>Md.</u>	
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>9-10-57</u>	
<b>22a. BURIAL, CREMATION, or other disposition</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>9-13-1957</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Hopewell</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Port Deposit, Md.</u> (State) <u>Rural</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee A. Patterson</u> ADDRESS <u>Perryville, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>G. L. Harris</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>G. L. Harris</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 17 1957

RECEIVED

## CERTIFICATE OF DEATH

## MEDICAL CERTIFICATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CENTRICATE OF DEATH

SEP 9 1967

BUREAU V. S.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09537

Reg. Dist. No. 182

9533

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Md</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>A</u> Last <u>BENNINGTON</u>		4. DATE OF DEATH Month <u>9</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 4 1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fortman of Bel Air Md</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Street Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Calvert Md</u>
13. FATHER'S NAME <u>FREDERICK E BENNINGTON</u>		14. MOTHER'S MAIDEN NAME <u>FLORANCE TARBERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give mgr or date of service) <u>Yes</u>		17. INFORMANT <u>Mrs Margaret L Bennington</u> Address <u>106 W Main St Bel Air Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING INJURY OF CHEST &amp; ABDOMEN</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ABDOMEN</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently run over by AUTO</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-1-9-21-57</u> Hour <u>12-1</u> a. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>PARKING LOT</u>		20f. (City or town) <u>Bel Air</u> (County) <u>HARTFORD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 24, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) <u>BEL AIR, HARTF. CO., MD.</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fisher</u> ADDRESS <u>West Broadway, BEL AIR, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9-21-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Paula L. Fournell</u>	



STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

SEP 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BALTIMORE, 18											
MAY 20b Film 220 9-13-57 ams											
9560											
CERTIFICATE OF DEATH											
Reg. Dist. No. 181											
1. PLACE OF DEATH a. COUNTY <b>Aberdeen Proving Ground</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harford</b> c. LENGTH OF STAY IN 1b <b>11 mos</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Hq &amp; Hq Det OTC</b> b. COUNTY <b>Aberdeen Prov Grd</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harfor</b> d. STREET ADDRESS <b>Aberdeen Prov Grd, X2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Jerome A. BRADY</b>					4. DATE OF DEATH Month <b>Sept</b> Day <b>1</b> Year <b>1957</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>17 August 1937</b>		9. AGE (In years last birthday) <b>20</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>			11. BIRTHPLACE (State or foreign country) <b>Cleveland, Ohio</b>			12. CITIZEN OF WHAT COUNTRY? <b>US Citizen</b>		
13. FATHER'S NAME <b>Mr. Edward Brady</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give year or dates of service) <b>6/20/56 to date</b>					16. SOCIAL SECURITY NO. <b>288-30-9455</b>		17. INFORMANT <b>Pfc. Richard Maye</b>			Address <b>Hq &amp; Hq Det OTC APG Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra-cerebral hemorrhage &amp; trauma</b> <b>976x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Gunshot wound, intra-cranial</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hours</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Circumstances unknown at this time/ Suicide</b>						
20c. TIME OF INJURY Month, Day, Year <b>unknown a. m. Sep 1 1957</b>					20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Barracks 5432</b>		20f. (City or town) <b>Aberdeen Proving Ground, Md.</b> (County) (State)		
21. I certify that I attended the deceased from <b>1300 1 Sep 1957</b> , to <b>1450 1 Sep 1957</b> , that I last saw the deceased alive on <b>1450 1 Sep 1957</b> , and that death occurred at <b>2:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____											
ACTUAL SIGNATURE <b>Charles C Weise</b>					M.D. <b>U.S. ARMY HOSPITAL APG MD</b> <b>1 September 57</b>						
PHYSICIAN'S NAME (Type) <b>Charles C. Weise, Capt, MC</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9/3/57</b>		22c. NAME OF CEMETERY OR CREMATORY _____			22d. LOCATION (City, town, or county) <b>Cleveland, Ohio</b> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Tamm</b>					ADDRESS <b>Aberdeen Md.</b>		24a. REC'D BY REGISTRAR <b>Sept 4-57</b>		24b. REGISTRAR'S SIGNATURE <b>Nellie G Perry</b>		

# CERTIFICATE OF DEATH

BUREAU V. S.

SEP 6 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9534

### CERTIFICATE OF DEATH

09539

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARDEGRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CONOWINGO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>07x0.2</u>	
3. NAME OF DECEASED (Type or print) <u>Baby girl Brammer (Twin A)</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>New born</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	9. AGE (In years last birthday) <u>1 yr.</u>
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>md.</u>	
13. FATHER'S NAME <u>Clyde Brammer Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Suzanne Cather</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clyde Brammer Jr.</u>		Address <u>Conowingo, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> <u>Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia - 2nd 2 1/2 yr. baby</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-25</u> , 19 <u>57</u> , to <u>9-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-25</u> , 19 <u>57</u> , and that death occurred at <u>2:20</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>9-26-57</u>	
PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr.</u>		ADDRESS (Street, city or town, state) <u>Port Deposit - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>9-25-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARTFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>HARDEGRACE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. [Signature]</u>		ADDRESS <u>Administrator Hospital</u>	
24a. REC'D BY REGISTRAR DATE <u>10-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. [Signature]</u>	

RECEIVED

OCT 3 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9535

CERTIFICATE OF DEATH

09540

Reg. Dist. No. 1855

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo</u>	
c. LENGTH OF STAY IN TB <u>18 hrs.</u>		d. STREET ADDRESS <u>Conowingo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John B. Baby Girl Brammer</u>		4. DATE OF DEATH Month Day Year <u>9 26 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25, 1957</u>
9. AGE (In years last birthday) yrs <u>18</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>MD</u>			
13. FATHER'S NAME <u>Clyde Brammer</u>		14. MOTHER'S MAIDEN NAME <u>Susanne Cather</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Clyde Brammer</u>	
17. INFORMANT <u>Clyde Brammer</u>		Address <u>Conowingo MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary At. Inf.</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 25</u> , 1957, to <u>Sept 26</u> , 1957, that I last saw the deceased alive on <u>Sept. 26</u> , 1957, and that death occurred at <u>4:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED <u>Sept 27, 1957</u>	
PHYSICIAN'S NAME (Type) <u>O. H. Richards Jr.</u>		ADDRESS (Street, city or town, state) <u>Fort Detrick - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>9-26-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARTFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>Harre de Grace MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Tully</u>		ADDRESS <u>Administrator - Hospital</u>	
24a. REC'D BY REGISTRAR <u>DATE 10-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

S. A. (11/11/1911)

100

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **0954185**  
**16**

**9536**

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harrods Grace -</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Harford Memorial Hosp</b>		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) <b>William James</b>		4. DATE OF DEATH <b>September 1 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-1911</b>
9. AGE (In years last birthday) <b>46 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician, Estimator, U.S.N. Hospital.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Amos M. Burlin</b>		14. MOTHER'S MAIDEN NAME <b>Eva M. McDonald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-03-7072</b>	
17. INFORMANT <b>Frances Burlin</b>		Address <b>Perryville Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Gerald E. Palmer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gerald E. Palmer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-4-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>	22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>9-3-57</b>		24b. REGISTRAR'S SIGNATURE <b>James E. Doughty</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

SEP 5 1957

RECEIVED

## 9537 CERTIFICATE OF DEATH

Reg. Dist. No. 182.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		LENGTH OF STAY (in this place) <u>4 mos 23 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>			
TOWN				STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 SO BOND.</u>				<u>108 SO. BOND</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SUSAN BLAIR</u> (Middle) <u>CAMPBELL</u> (Last)				(Month) <u>SEPT</u> (Day) <u>2</u> (Year) <u>19 57</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>APRIL 8, 1957</u>	9. AGE last birthday <u>4</u> yrs. <u>25</u> Months <u>5</u> Days	IF UNDER 1 YEAR Hours <u>57</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES BURTON CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>MILDRED ESTELLE DUFF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>MOTHER BEL AIR, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
7-4 IMMEDIATE CAUSE (A) <u>PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CONGENITAL HEART</u>						<u>SINCE BIRTH</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4-7-57</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>AUG 31</u> , 19 <u>57</u> , to <u>SEPT 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>SEPT 2</u> , 19 <u>57</u> , and that death occurred at <u>2:25 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Neuman</u>				ADDRESS (Street, city, town, state) <u>307 Hickory, Bel Air, Md</u>			
DATE <u>9-3-57</u>				DATE SIGNED <u>SEPT 2, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>Sept 3/57</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air, MD</u>	
24. REC'D BY REGISTRAR <u>9-3-57</u>		REGISTRAR'S SIGNATURE <u>Priscilla Toward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		ADDRESS <u>Bel Air, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled-in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

RECEIVED

SEP 5 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9538

## CERTIFICATE OF DEATH

09543

Reg. Dist. No.

186

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hairc. de Grace</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Memorial Hospital</b>				d. STREET ADDRESS <b>Street, Md</b>			
3. NAME OF DECEASED (Type or print) First <b>Sallie</b> Middle <b>C.</b> Last <b>CARR</b>				4. DATE OF DEATH Month <b>September</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 7, 1884</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>DUBLIN, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES McCANN</b>				14. MOTHER'S MAIDEN NAME <b>CARRIE HOPKINS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MYRON CARR, BELAIR, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Heart Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b> <b>5 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe hypochromic anemia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-12-57</b> to <b>9-19-57</b> that I last saw the deceased alive on <b>SEPTEMBER 12, 1957</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8 Law St Aberdeen, Md.</b> DATE SIGNED <b>9-20-57</b>							
ACTUAL SIGNATURE <b>Peter P. Rodman, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EMORY</b>		22d. LOCATION (City, town, or county) (State) <b>STREET, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins, Delta, Pa.</b>				24a. REC'D BY REGISTRAR DATE <b>9-23-57</b>		24b. REGISTRAR'S SIGNATURE <b>G. L. Lewis, Jr.</b>	

BUREAU V. S.

SEP 24 1907

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09544/185  
Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u> c. LENGTH OF STAY IN TB <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>1R + 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>William Jacob Carroll</u> First Middle Last <b>4. DATE OF DEATH</b> <u>September 17 1957</u> Month Day Year				<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>5-1-79</u> <b>9. AGE</b> (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>VA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>UNKNOWN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input checked="" type="checkbox"/>		<b>16. SOCIAL SECURITY NO.</b> <input checked="" type="checkbox"/>		<b>17. INFORMANT</b> <u>Mary Carroll</u> Address <u>Bel Air MD</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture L. Femur</u> DUE TO <u>fall</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in his yard</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>9-7</u> 19 <u>57</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Bel Air</u> (County) <u>Harford</u> (State) <u>MD</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Gerald C. Palmer</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <u>Harford County</u>		<b>DATE SIGNED</b> <u>9-17-57</u>	
<b>EXAMINER'S NAME (Type)</b> <u>Gerald C. Palmer</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <u>Bel Air</u>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>MD</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried</u>		<b>22b. DATE THEREOF</b> <u>Sept 19/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Watkins Memorial</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Croftown</u> (State) <u>Harford MD</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph J. Tinto</u> ADDRESS <u>Bel Air MD</u>				<b>24a. REC'D BY REGISTRAR</b> <u>P 23-1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Michael L. Lewis</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

RECEIVED

9561

## CERTIFICATE OF DEATH

Reg. Dist. No. 17

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEWOOD</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEWOOD</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US ARMY HOSPITAL</b>				d. STREET ADDRESS <b>ARMY CHEMICAL CENTER</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALVIN</b> Middle <b>VIRGIL</b> Last <b>CLINE</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>4</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 July 1937</b>		9. AGE (In years last birthday) yrs. <b>20</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOLDIER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US ARMY</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SILAS VIRGIL CLINE</b>				14. MOTHER'S MAIDEN NAME <b>KATHLEEN ATWOOD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>236-58-0287</b>		17. INFORMANT <b>OFFICIAL US ARMY RECORDS</b>		Address <b>H.P.C. 2nd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRAGE AND EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>TRAUMA TO HEAD</b> DUE TO (c) <b>AUTOMOBILE ACCIDENT</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>AUTOMOBILE WENT OVER EMBANKMENT</b>					
20c. TIME OF INJURY Month, Day, Year <b>12:04 a.m. Sept 4 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>STREET</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 Sept. 1957</b> to <b>4 Sept. 1957</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>12:04 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>US Army Hospital Aberdeen Proving Ground, Maryland</b> DATE SIGNED <b>4 Sept 1957</b>							
ACTUAL SIGNATURE <b>Harlan W. Hawkinson</b> M.D.							
PHYSICIAN'S NAME (Type) <b>HARLAN W HAWKINSON</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Mullens West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Sarring</b> <b>aberndeen, md.</b>				24a. REC'D BY REGISTRAR <b>DATE 10-10-57</b>		24b. REGISTRAR'S SIGNATURE <b>William G. Perry</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. F.

SEP 9 1957

RECEIVED

9562

## CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Hartford</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Cross Roads</u>		c. LENGTH OF STAY IN TB <u>75 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Cross Roads</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>Fallston R. D.</u>			
3. NAME OF DECEASED (Type or print) <u>Catherine Virginia Cochran</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>AUG 13 1872</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George Stephen</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Robert Six Fallston Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA, ACUTE</u> <u>440.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ABCESS, RT. UPPER THIGH</u> DUE TO (c) <u>HYPERTENSIVE - ARTERIOSCLEROTIC HEART DIS.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>7 DAYS</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>57</u> , to <u>Sept</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 4</u> 19 <u>57</u> , and that death occurred at <u>2:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. James Thomson, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Jarrettsville, Md</u> DATE SIGNED <u>9/6/57</u>			
PHYSICIAN'S NAME (Type) <u>S. JAMES THOMSON, JR. MD.</u>				<u>JARRETTSVILLE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Hydes, Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Raut Jarrettsville Md</u>				24a. REC'D BY REGISTRAR <u>DATE 9-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Fourvork</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

SEP 13 1957

RECEIVED

9540

## CERTIFICATE OF DEATH

Reg. Dist. No.

0954785

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Home-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>30 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>	
		d. STREET ADDRESS <u>Rt # 1</u>	
3. NAME OF DECEASED (Type or print) <u>David</u> First Middle Last		4. DATE OF DEATH <u>9</u> Month <u>14</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 6 - 1943</u>
		9. AGE (In years last birthday) <u>13</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GROVER COLDIRON</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
		17. INFORMANT <u>GROVER COLDIRON BEL AIR, Md. Rt # 1</u> Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of aortic aneurysm with</u> DUE TO <u>hemopericardium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Syphilitic Aortitis</u> DUE TO <u>Congenital Syphilis</u> (c) <u>Congenital Syphilis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>about 2 hrs</u> <u>Congenital</u> <u>Congenital</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac decompensation, Congenital hypoplasia - left kidney</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 13th 1957</u> to <u>Sept. 14 1957</u> , that I last saw the deceased alive on <u>Sept. 14th 1957</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Lee, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>		DATE SIGNED <u>9/15/57</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 17/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bell Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Hartford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. ...</u>		24a. REC'D BY REGISTRAR <u>SEP 17 1957</u>	
ADDRESS <u>...</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. H. L. Lewis</u>	

THIS CERTIFICATE IS ATTENDED BY PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 17 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9541

CERTIFICATE OF DEATH

09548

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARVE DE GRACE</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ABERDEEN</b>			
f. STREET ADDRESS <b>141 OSBORNE Rd.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary MARIAN</b> First <b>Marian</b> Middle <b>COLE</b> Last				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>21</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/5/1884</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas E. Kirby</b>				14. MOTHER'S MAIDEN NAME <b>Mary Dugan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Chas. A. Kirby, Aberdeen, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Snanton</b> X DUE TO <b>Paranoma of head of pancreas</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>~ 2 mos</b> <b>~ 18 mos</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Aug 15, 1957</b> to <b>Sept 21, 1957</b> , that I last saw the deceased alive on <b>Sept 20, 1957</b> , and that death occurred at <b>2:15 P.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. J. Plunkett, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Aberdeen, Md.</b>		DATE SIGNED <b>9-21-57</b>	
PHYSICIAN'S NAME (Type) <b>B. J. Plunkett, Jr.</b>				<b>Aberdeen - Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/24/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. [Signature]</b>				ADDRESS <b>Aberdeen, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>9-24-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Ch. L. [Signature]</b>			

BUREAU V. 3

SEP 25 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09549  
180

9563

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u>	c. LENGTH OF STAY IN 1b <u>38 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Demby Town</u>		d. STREET ADDRESS <u>Demby Town</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALEXANDER</u> <u>DEMBY</u>		4. DATE OF DEATH Month Day Year <u>SEPT</u> <u>18</u> <u>19 57</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26, 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Washington Demby</u>		14. MOTHER'S MAIDEN NAME <u>Maria Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Blanche Demby, Magnolia, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Arterio-sclerotic Cardiovascular</u> DUE TO (c) <u>Disease with Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>Magnolia, Harford, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Sept 19, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 22, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>	22d. LOCATION (City, town, or county) (State) <u>Magnolia, Harford, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs</u>		24a. REC'D BY REGISTRAR <u>Sept. 22, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Norma E. Moore</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

RECEIVED

SEP 24 1967

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9564 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09550  
Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Cordelia</u> First <u>Edwards</u> Middle <u>Edwards</u> Last		4. DATE OF DEATH <u>September</u> Month <u>29</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17 1888</u>
9. AGE (in years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MC</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Floyd Crouse</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Gambrell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Floyd Edwards</u> Address <u>Forest Hill MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third degree burns entire body</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>House caught fire</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>6</u> Hour <u>9-24</u> p.m. <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Forest Hill</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. A. in</u> DATE SIGNED <u>9-25-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 27</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Peet Creek</u>		22d. LOCATION (City, town, or county) <u>Chesnut Hill</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. ...</u> ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>9-30-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Muriella Lowwood</u>			

MEDICAL CERTIFICATION

12

TO THE CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

OCT 2 1900

RECEIVED

9542

CERTIFICATE OF DEATH

09551

Reg. Dist. No. 150

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harrie</u>		4. DATE OF DEATH Month Day Year <u>Sept. 17 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday) yrs. Months Days Hours Min. <u>29 30</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. MOTHER'S MAIDEN NAME <u>Mildred R. Harrie</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 16, 1957</u> to <u>Sept. 17, 1957</u> , that I last saw the deceased alive on <u>Sept 17, 1957</u> , and that death occurred at <u>145 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>George J. Stansbury</u>		M.D. <u>569 Revolution St. Harre de Grace, Md. 9/19/57</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		<u>HARRE DE GRACE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9-17-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>Harre de Grace Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Harry R. Tully Administrator</u>		24a. REC'D BY REGISTRAR DATE <u>9-27-57</u>	24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>

RECEIVED  
SEP 3 1957  
BUREAU V. S.

9565

## CERTIFICATE OF DEATH

09552/82  
Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Norrisville</b>		c. LENGTH OF STAY IN 1b <b>5yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Clarence</b> Last <b>Heaps</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>5</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 8, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>David W. Heaps</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth King</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>Nannie Heaps, White Hall RD, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency due to</b> DUE TO <b>heart failure, chronic myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>+ angina</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 12, 1956</b> to <b>Sept. 5, 1957</b> , that I last saw the deceased alive on <b>Sept. 3, 1957</b> , and that death occurred at <b>1:00 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Norman H. Gemmill</b>		ADDRESS (Street, city or town, state) <b>Stewartstown, Pa.</b> DATE SIGNED <b>Sept. 5, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Norman H. Gemmill</b> <b>Stewartstown, Penna.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-8-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ayres Chapel Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>White Hall RD, Harford Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth W. Crishen</b>		24a. REC'D BY REGISTRAR ADDRESS <b>Stewartstown, Penna.</b>	24b. REGISTRAR'S SIGNATURE <b>Russella Forward</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 10 1957

RECEIVED



## CERTIFICATE OF DEATH

09553  
185

Reg. Dist. No.

9543

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELCAMP, MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>BELCAMP, MARYLAND</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMILY N. HESOUN</u>		4. DATE OF DEATH Month Day Year <u>SEPTEMBER 23 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July, 16, 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Store</u>	
11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CYRIL STETKER</u>		14. MOTHER'S MAIDEN NAME <u>Josephina Kopecek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>215-18-6857</u>	
17. INFORMANT <u>JAMES HESOUN</u>		Address <u>BELCAMP, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO <u>Bronchogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>15 months</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15th, 1957</u> , to <u>Sept. 22, 1957</u> , that I last saw the deceased alive on <u>Sept. 22nd, 1957</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Lee, M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>211 North Union Ave. 9/23/57</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>		<u>Haure de Grace Ind</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 25, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>	22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard McBratney</u>		ADDRESS <u>Abingdon, Md.</u>	
24a. DATE BY REGISTRAR <u>SEP 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>A. Z. Lounsbury</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

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SEP 28 1977

BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

323 N Sherman Drive  
Indianapolis, Indiana

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09554

9566

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3/ Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Deborah Sue Hill		4. DATE OF DEATH Month September Day 5 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 5, 1957
9. AGE (In years last birthday) yrs. 8 15		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Franklin Hill		14. MOTHER'S MAIDEN NAME Barbara Allen Perry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Father		Address (same as in 2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 777 Premature birth DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Sept 19 57, to 5 Sept 19 57, that I last saw the deceased alive on 5 Sept 12 57, and that death occurred at 1115 a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE E W Watts Jr. Capt MC M.D. US Army Hospital 5 Sept 1957 PHYSICIAN'S NAME (Type) E W WATTS JR, Capt, MC Aberdeen Proving Ground, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/1957	
22c. NAME OF CEMETERY OR CREMATORY Post Remedy		22d. LOCATION (City, town, or county) (State) Aberdeen Proving G. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Lanning		24. REC'D BY REGISTRAR DATE Sept - 57	
ADDRESS Aberdeen, Md		24b. REGISTRAR'S SIGNATURE Nellie R. Jones	

10000161XVO

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SEP 9 1957

BUREAU V. S.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 189

9567

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL (give nearest town)) <u>Potteryville</u>		c. LENGTH OF STAY IN 1b <u>9 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potteryville</u>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Ernest E Hyatt</u>				4. DATE OF DEATH <u>September 6 1957</u>			
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8, 1883</u>	9. AGE (in years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel mills</u>		11. BIRTHPLACE (State or foreign country) <u>Indian Valley, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>XXXXXX</u>				14. MOTHER'S MAIDEN NAME <u>Nora Belle Hylton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1911</u>		16. SOCIAL SECURITY NO. <u>213-09-2074</u>		17. INFORMANT Address <u>Mrs. Ida K. Hylton, Stewartstown RD#1, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C</u> <u>422.1</u> DUE TO <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		Be/Ais. Md		DATE SIGNED <u>9-7-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. ...</u>		ADDRESS <u>Stewartstown, Penna.</u>		24a. REC'D BY REGISTRAR DATE <u>9.9.57</u>		24b. REGISTRAR'S SIGNATURE <u>Prudence Lowmood</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 16 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The form must be completed by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

## CERTIFICATE OF DEATH

Reg. Dist. No.

0955685

9544

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>	
c. LENGTH OF STAY IN 1b <b>25 HRS.</b>		d. STREET ADDRESS <b>522 Young</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby</b> First Middle Last <b>Jordan</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>18</b> Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 17, 1957</b>
9. AGE (In years lost birthday) yrs <b>1</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>OTIS Jordan</b>		14. MOTHER'S MAIDEN NAME <b>Effie Keel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> (c) <b>Prematurity</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept. 17, 1957</b> to <b>Sept. 19, 1957</b> , that I last saw the deceased alive on <b>Sept. 18, 1957</b> , and that death occurred at <b>12:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>529 Revolution St. Haure de Grace, Md.</b> DATE SIGNED <b>9/19/57</b>			
ACTUAL SIGNATURE <b>George T. Stansbury</b>		M.D. <b>529 Revolution St. Haure de Grace, Md.</b>	
PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>		<b>HAURE DE GRACE, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>9-17-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HARFORD Memorial Hospital</b>	22d. LOCATION (City, town, or county) (State) <b>Haure de Grace, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry R. Tully</b>		24a. REC'D BY REGISTRAR DATE <b>9-27-57</b>	
24b. REGISTRAR'S SIGNATURE <b>A. L. Tully M.D.</b>			

BUREAU V. 5

SEP 1957

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9568

CERTIFICATE OF DEATH

09557

Reg. Dist. No.

182

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Bush Corner 7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Glen Arm</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Rocks" Home</u>		d. STREET ADDRESS <u>Glen Arm Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Harvey E</u> Middle <u>Kahn</u> Last <u>Kahn</u>		4. DATE OF DEATH Month <u>Sept</u> - Day <u>3</u> - Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31-1896</u>
9. AGE (in years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (State or foreign country) <u>Balds. md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henni Chas. Kahn</u>		14. MOTHER'S MAIDEN NAME <u>Janet Mc Kenzie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Wm E Kahn Jr</u>		Address <u>Glen Arm - md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Pneumonia</u> <u>422.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>8 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/26</u> , 19 <u>57</u> , to <u>9/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/2</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. James Thonilon, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Janettsville, Md.</u> DATE SIGNED <u>9/3/57</u>	
PHYSICIAN'S NAME (Type) <u>S. JAMES THONILON, Jr., M.D.</u>		Address <u>Janettsville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept-6-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Cokeville - md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward M. Mervale</u>		ADDRESS <u>108 W York - Balt</u>	
24a. REC'D BY REGISTRAR <u>SEP 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director's name and address. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

7 6 1957

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09558

## 9569 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Harford</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Fallston</b>		<b>2 Months</b>		TOWN <b>Bel Air</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Harford County Home</b>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<b>Gertrude T. Kimble</b>				<b>Sept. 13 19 57</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>December 18, 1875</b>	<b>81</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>House Wife</b>						<b>Maryland</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Herman Thomas</b>				<b>Agusta Bendorf</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<b>No</b>				<b>✓</b>		<b>Deceased</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Coronary Occlusion</b>						<b>Sudden</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July</b> ....., 19 <b>57</b> ....., to <b>Sept. 13</b> ....., 19 <b>57</b> ....., that I last saw the deceased alive on <b>Sept. 11</b> ....., 19 <b>57</b> ....., and that death occurred at <b>5:00 A.M.</b> , from the causes and on the date stated above.							
SIGNATURE <b>Willard P. Hudson</b> M.D.				DATE SIGNED <b>Sept. 13, 1957</b>			
ADDRESS (Street, city, town, state)				ADDRESS <b>Forest Hill, Md.</b>			
23. BURIAL, CREMATON, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Sept 15 1957</b>		<b>St Paul's Lutheran</b>		<b>TERRYMUN RD Harford, Md</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>9-14-57</b>		<b>Prueilla Lowwood</b>		<b>Joseph J. Tinto</b>		<b>Bel Air Md</b>	

RECEIVED

SEP 17 1957

REAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9570

## CERTIFICATE OF DEATH

09559

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEWOOD</b>				c. LENGTH OF STAY IN 1b <b>7 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>APT. 259 ARMY CHEMICAL CENTER</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEWOOD</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CAMILLA EMELIA KOGLER</b>				4. DATE OF DEATH Month Day Year <b>SEPTEMBER 17, 1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1881</b>	9. AGE (In years last birthday) <b>76</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>EMIL PIRATH</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs Sybil Moree</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Lungs</b> DUE TO (c) <b>Carcinoma of breast</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Edgewood, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>July 1955</b> to <b>Sept 17, 1957</b> , that I last saw the deceased alive on <b>Sept 16, 1957</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above							
ACTUAL SIGNATURE <b>P. B. Hopkins</b>				M.D. <b>229A, Edgewood, Md.</b>			
PHYSICIAN'S NAME (Type) <b>P. B. Hopkins</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 19, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Lutheran Cem. Baltimore Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC. BALTIMORE MD.</b>				23a. REC'D. BY REGISTRAR <b>SEP 20 1957</b>		23b. REGISTRAR'S SIGNATURE <b>Norma Moore</b>	

RECEIVED  
SEP 27 1957  
BUREAU V. S.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 185-

9545

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Ad Penna</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. LENGTH OF STAY IN 1b <u>-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOT Harford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>	
f. STREET ADDRESS <u>5430 Lebanon Ave</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mimmie</u> First <u>Korman</u> Last		4. DATE OF DEATH <u>September 7</u> 19 <u>57</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>57</u> yrs.
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Schanberg</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Brownstein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Isadore Schanberg</u> Address <u>1813 Champlain Ave</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>9-7-57</u> Hour <u>6</u> a.m. <u>pm</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HS</u>		20f. (City or town) <u>Fallston</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Be/Air Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Equal</u>		22b. DATE THEREOF <u>9/8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>not known</u>		22d. LOCATION (City, town, or county) <u>Philadelphia</u> (State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isadore Schanberg</u> ADDRESS <u>1813 Champlain Ave</u>		24a. REC'D BY REGISTRAR <u>G. L. Lewis M.D.</u>	
		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please enclose a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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SEP 11 1957

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09561

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

9546

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>J.</u> Last <u>Kreiner</u>		d. STREET ADDRESS <u>Box 425E RD 1</u>	
4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>1957</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIPPING CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry John Kreiner</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Leonard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Gerald J. Kreiner</u> Address <u>Box 425E Rd 1 Bel Air Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause lost. DUE TO (c) <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air Md. DATE SIGNED <u>9-10-57</u>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>9-11-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Aucilla Howard</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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SEP 18 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09562

Reg. Dist. No. 185

## CERTIFICATE OF DEATH

9547

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harbe Del Grace.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Pearl U. KROUSE</u>				4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 May 1888</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 74 HRS Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard J Brown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>G. Cleveland Krouse</u> Address <u>614 W Bol Air</u> <u>Aberdeen, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial insufficiency</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 year</u> <u>&gt;5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>55</u> to <u>Sept 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 10</u> , 19 <u>57</u> , and that death occurred at <u>1235</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B.J. Plunkett Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>617 W. Bol Air Ave.</u> DATE SIGNED <u>9-10-57</u>			
PHYSICIAN'S NAME (Type) <u>B.J. Plunkett Jr. M.D.</u>				<u>Aberdeen, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. #2 Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Farney</u>				ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9-12-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. Kenyon M. H.</u>			

BUREAU V. S.

SEP 13 1957

RECEIVED

## Reg. Dist. No.

**MEDICAL CERTIFICATION**

BUREAU V. S.

CT 1 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 See 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

9571

CERTIFICATE OF DEATH

09564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Clayton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital</b>		d. STREET ADDRESS <b>PO Box 121 9 Defense Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Dondoe</b> Middle <b>Earl</b> Last <b>Maddox</b>		4. DATE OF DEATH Month <b>September</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 18 1957</b>
9. AGE (In years last birthday) yrs. <b>3</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Earl Maddox</b>		14. MOTHER'S MAIDEN NAME <b>Bennie Lee Farrior</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Father (as in 2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cause unknown, possible intracranial hemorrhage</b> <b>1546</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital abnormality of great vessels</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. 11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 18</b> , 19 <b>57</b> , to <b>Sept 21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept 21</b> , 19 <b>57</b> , and that death occurred at <b>0620a</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W M MICHENER Capt MC</b>		ADDRESS (Street, city or town, state) <b>US Army Hospital Aberdeen Proving Ground, Md</b>	
PHYSICIAN'S NAME (Type) <b>W M MICHENER Capt MC</b>		DATE SIGNED <b>Sept 21 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/24/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Post Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen Proving Ground Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Sarrang</b>		ADDRESS <b>Aberdeen Md</b>	
24a. REC'D BY REGISTRAR <b>Sept 25-57</b>		24b. REGISTRAR'S SIGNATURE <b>Helvie R. Perry</b>	

BUREAU V. S.

SEP 27 1955

RECEIVED



9549

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert A. Wilson McCauley</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/30/1937</u>
9. AGE (In years last birthday) <u>20</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kent Freight Lines</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Keller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-36-1776</u>	
17. INFORMANT <u>Harold Wilson</u>		Address <u>Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO (b) <u>Ovarian</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Dysgerminoma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/11</u> , 19 <u>57</u> , to <u>9/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/2</u> , 19 <u>57</u> , and that death occurred at <u>1:15 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. J. Hatern</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>12 N. Philadelphia Rd., Aberdeen, Md. 9/1/57</u>	
PHYSICIAN'S NAME (Type) <u>J. J. Hatern</u>		<u>Aberdeen Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/5/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin 17 Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarning</u>		24a. REC'D BY REGISTRAR DATE <u>9-5-57</u>	
ADDRESS <u>Aberdeen Md.</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 9 1957

BUREAU V. S.

9572

## CERTIFICATE OF DEATH

Reg. Dist. No.

182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Hugh Jones Mc Nutt</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1886-71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired Farmer</u>		11. BIRTH PLACE (State or foreign country) <u>Harford Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Hugh J. Mc Nutt</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> (If yes, give war and dates of service)		16. SOCIAL SECURITY NO. <u>220-18-8445</u>	
17. INFORMANT <u>Mrs. Hught Mc Nutt</u>		Address <u>Harlington Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Cerebral Sclerosis</u> DUE TO <u>Cerebral Vascular Syn</u> (c) <u>Dissecting</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jun 1</u> , 19 <u>50</u> , to <u>Sept 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>57</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u>		DATE SIGNED <u>9/17/57</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>		ADDRESS (Street, city or town, state) <u>Harlington Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>Sept. 19, 1957</u>	<u>Harlington</u>	<u>Harlington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Bailey</u>		ADDRESS <u>Harlington Md</u>	
24a. READ BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>C. V. Kirk</u>	
DATE <u>Sept. 17, 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 07 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09567  
Reg. Dist. No. 182

9550

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN 1b <u>4 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>417 Maitland</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>417 Maitland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Roscoe Earl Phipps</u> First Middle Last <b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>B. DATE OF BIRTH</b> <u>June 24/1917</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>40</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Wholesale Grocery Merchant</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Grass Creek N.C</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>US</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>				<b>4. DATE OF DEATH</b> <u>September 30</u> 19 <u>57</u> Month Day Year <b>13. FATHER'S NAME</b> <u>Peta Phipps</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>DORRINE Brienfer</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>217-18-1093</u> <b>17. INFORMANT</b> <u>Coy N Phipps</u> Address <u>412 Maitland St Bel Air Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND CEREBRUM</u> DUE TO (b) <u>71a X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/> <u>shot self with pistol</u> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>9-30-57</u> Hour a. m. p. m. <u>7</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> <u>Bel Air</u> (County) <u>Harford</u> (State) <u>Md.</u>				<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <b>ACTUAL SIGNATURE</b> <u>Lorald C Palmer</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME</b> (Type) <u>Gerold C Palmer - MD</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>22b. DATE THEREOF</b> <u>Oct 3/1957</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Bel Air Memorial Gardens</u> <b>22d. LOCATION</b> (City, town, or county) (State) _____		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph J Foster</u> ADDRESS <u>Bel Air Md</u> <b>24a. REC'D BY REGISTRAR</b> <u>9-30-57</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Puella Lownd</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

OCT 2

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9551

## CERTIFICATE OF DEATH

09568

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>10 HRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>	
		d. STREET ADDRESS <b>413 S. STOKES</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARVIL LEROY ROBINSON JR.</b>		4. DATE OF DEATH Month Day Year <b>SEPT. 16 1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-4-56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (In years lost birthday) yrs <b>20</b> Months <b>20</b> Days <b>20</b> Hours <b>20</b> Min <b>20</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CARVIL LEROY ROBINSON, SR.</b>		14. MOTHER'S MAIDEN NAME <b>ALMA LEE HIGGINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Alma Robinson, Harford, Md.</b>		Address <b>413 S. Stokes St. Harford, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Fulminating Pneumonia (Bilateral)</b> DUE TO (b) <b>Toxemia with Bacteremia</b> DUE TO (c) <b>Pharyngitis with Bronchitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b> <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept. 13, 1957</b> to <b>Sept. 16, 1957</b> , that I last saw the deceased alive on <b>Sept. 16, 1957</b> , and that death occurred at <b>6:56 P.M.</b> from the causes and on the date stated above.			
PHYSICIAN'S SIGNATURE <b>George T. Stansbury</b> M.D.		DATE SIGNED <b>9/16/57</b>	
PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>		Address <b>Harford, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-18-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fair View Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Freet Hill Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. J. Bullock - Harford, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 9-17-57</b>	24b. REGISTRAR'S SIGNATURE <b>G. H. Henshaw Jr.</b>

RECEIVED

SEP 19 1957

BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09569  
Reg. Dist. No. 785-

9552

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please  
execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>DOROTHY E. STANDIFORD</b>		4. DATE OF DEATH Month <b>September</b> Day <b>8</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22 1920</b>
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>Housework at home</b>		11. BIRTHPLACE (State or foreign country) <b>Harford Co. Md., U. S. A.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>Geo. Standiford</b>		14. MOTHER'S MARRIAGE NAME <b>Helen Starr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-18-9803</b>	
17. INFORMANT <b>Grayham Standiford</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Barbiturate Poisoning</b> 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Took overdose of barbiturates</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9/8</b> a. m. <b>1957</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> <b>home</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Havre de Grace Harford Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		DATE SIGNED <b>9/9/57</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		M D CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, (Specify)		22b. DATE THEREOF <b>Sept 11, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Run Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Harford Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Bailey</b>		24a. REC'D BY REGISTRAR <b>Sept 16, 1957</b>	
ADDRESS <b>Harlington, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>G. L. Lewis</b>	

BUREAU V. S.

SEP 13 1957

RECEIVED

VS. AISME(5)  
SM 9/55

957M

09570

1. PLACE OF DEATH a. COUNTY <u>H&amp;T-501-d</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H&amp;T-501-d</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. LENGTH OF STAY IN 1b <u>15 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Joppa</u>	
3. NAME OF DECEASED (Type or print) <u>Ann F. Sullivan</u>		4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 4, 1897</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Proprietor</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Frank</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Kawa</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Jennie B. Demby, Magnolia, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerard C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Sept 13, 1957</u>	
EXAMINER'S NAME (Type) <u>Gerard C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		9-10-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 13, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward R. McGowan Jr</u>		ADDRESS <u>Abingdon Maryland</u>	
24a. REC'D BY REGISTRAR <u>Sept 13, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Norma B. Moore</u>	

BUREAU V. S.

SEP. 16 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>15 HRS 29 MIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>Kails Apts - Sleepy Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>TAMM</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>0</u> yrs		F UNDER 1 YEAR: Months <u>15</u> Days <u>29</u> IF UNDER 24 HRS.	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>TAMM, FRED C.</u>				14. MOTHER'S MAIDEN NAME <u>WEEKS - Wardell Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Haap. Records - Haure de Grace, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE (AND PREMATUREITY)</u>							
DUE TO <u>1699</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MATERNAL HEPATITIS AND PNEUMONIA WITH HIGH FEVER FOR 1 WEEK PRIOR TO BIRTH</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>SEPT. 12, 1957</u> to <u>SEPT. 13, 1957</u> that I last saw the deceased alive on <u>9-13-57</u> 19 <u>57</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. J. J. Norman M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>Haure de Grace Md</u> DATE SIGNED <u>9-13-57</u>			
PHYSICIAN'S NAME (Type) <u>1713, No. 1000 T</u>				<u>HAURE DE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>9-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSP.</u>		22d. LOCATION (City, town, or county) (State) <u>HAURE DE GRACE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Zully administrator</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>9-14-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

RECEIVED  
SEP 23 1957  
BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9554

CERTIFICATE OF DEATH

09572, 85-  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>				c. LENGTH OF STAY IN 16 <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARFORD MEMORIAL Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. STREET ADDRESS <u>302 Edmund Street</u>							
3. NAME OF DECEASED (Type or print) First <u>JUDITH</u> Middle <u>ANN</u> Last <u>TOWNS</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/57</u>	9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min <u>3</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Infant</u>							
13. FATHER'S NAME <u>Robert M Towns</u>				14. MOTHER'S MAIDEN NAME <u>Joyce Ann Wise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>—</u>			
17. INFORMANT <u>Mother</u>				Address <u>302 Edmund St., Aberdeen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>755X</u> DUE TO <u>Atelactasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Probable Congenital Defect</u> DUE TO <u>—</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cleft palate</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/29</u> , 19 <u>57</u> , to <u>9/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/1</u> , 19 <u>57</u> , and that death occurred at <u>5:00</u> M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>17 N. Phila - Rd., Aberdeen, Md.</u>				DATE SIGNED <u>9/1/57</u>			
ACTUAL SIGNATURE <u>F. J. Hatem</u>							
PHYSICIAN'S NAME (Type) <u>F. J. Hatem</u>				<u>Aberdeen - Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>APG. Post Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aber. Prov. Gds. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Volney G. Harvey</u>				ADDRESS <u>333 S. Parke St. Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9-6-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			

BUREAU V. S.

SEP 9 1957

RECEIVED



9555

## CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1 PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) II institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARTFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>303 WILSON ST</u>		d. STREET ADDRESS <u>303 WILSON ST</u>	
3 NAME OF DECEASED (Type or print) <u>CHARLES PICKARD TWOMBLY</u>		4. DATE OF DEATH <u>SEPT. 11 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 26, 1958</u>
9. AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>M. H.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK TWOMBLY</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE SANBORN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>The Rose J. Twombly 303 WILSON ST.</u>	
17. INFORMANT <u>The Rose J. Twombly</u>		Address <u>303 WILSON ST.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis with myocardial infarction</u> DUE TO <u>Anteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anteriosclerotic Cardiovascular Disease</u> DUE TO <u>Disease</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>14 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug. 28th, 1957</u> to <u>Sept. 11th, 1957</u> that I last saw the deceased alive on <u>Sept. 11th, 1957</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Lee, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u> DATE SIGNED <u>9/12/57</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>		<u>Havre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept. 14, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM</u>	22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>HAVRE DE GRACE MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE 9-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lomas, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar.

RECEIVED

SEP 16 1957

BUREAU V. S.

9556 **CERTIFICATE OF DEATH**

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <b>Hall St.</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Mary</b>		(Middle) <b>Ellen</b>		(Last) <b>Watters</b>		(Month) <b>9</b> (Day) <b>24</b> (Year) <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>9/15/1882</b>	9. AGE last birthday <b>75yr</b>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>John Henry Smith</b>				14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Jacob M. Watters- Husband Bel Air, Md.</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
171X IMMEDIATE CAUSE (A) <b>Carcinomatosis; widespread, metastatic</b>				<b>4 months</b>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <b>Carcinoma of cervix</b>				<b>3 years</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>January</b> , 1955, to <b>Sept. 24</b> , 1957, that I last saw the deceased alive on <b>Sept. 20</b> , 1957, and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Paul S. Stonesifer Jr.</b>				ADDRESS (Street, city, town, state) <b>M.D. 115 Fulford Ave., Bel Air, Md.</b>		DATE SIGNED <b>9/25/57</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		DATE THEREOF <b>Sept 27/57</b>		NAME OF CEMETERY OR CREMATORY <b>Mountain Methodist</b>		LOCATION (City, town, or county) (State) <b>Mountain Harford Md</b>	
24. REC'D BY REGISTRAR <b>9.25-57</b>		REGISTRAR'S SIGNATURE <b>Pravella Lowood</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph T. Jones</b>			

INSTRUCTIONS

1. TO ATTESTING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M

RECEIVED  
SEP 27 1957  
BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

9557

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>				c. LENGTH OF STAY IN 1b <i>48 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				d. STREET ADDRESS <i>R. F. D. # 2</i>			
3. NAME OF DECEASED (Type or print) First <i>Nina</i> Middle <i>B.</i> Last <i>White</i>				4. DATE OF DEATH Month <i>9</i> Day <i>21</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 8, 1910</i>	
9. AGE (In years last birthday) <i>46 yrs.</i>		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>13</i> Hours <i></i> Min. <i></i>		11. BIRTHPLACE (State or foreign country) <i>Hillsville, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i></i>			
13. FATHER'S NAME <i>George Harris</i>				14. MOTHER'S MAIDEN NAME <i>Bertha Reeves</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-32-3930</i>		17. INFORMANT <i>Mrs. Ben White, Street, Md.</i> Address <i>R. F. D. # 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>442X</i> DUE TO (b) <i>Renal Insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Hypertensive Cardiovascular disease</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>Aug. 5, 1957</i> , to <i>Sept. 21, 1957</i> , that I last saw the deceased alive on <i>Sept. 21, 1957</i> , and that death occurred at <i>8:20 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>George T. Stansbury</i>				ADDRESS (Street, city or town, state) <i>569 Revolution St., Harre de Grace, Md.</i>			
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>				DATE SIGNED <i>9/21/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-25-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Clark's Chapel Am.</i>		22d. LOCATION (City, town, or county) (State) <i>Falmouth, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Atelia J. Bullock</i>				ADDRESS <i>Harre de Grace, Md.</i>		24a. REC'D BY REGISTRAR <i>G. L. K...</i>	
24b. REGISTRAR'S SIGNATURE				DATE <i>9-23-57</i>		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 17 1937



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

180

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Westmoreland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensburg</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>Greensburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anthony's Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>O</u> Last <u>White</u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 4, 1905</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parking Lot Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Greensburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham White</u>		14. MOTHER'S MAIDEN NAME <u>Emma J. Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Helen W. White, Greensburg, Penna.,</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Harford County</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>  </u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>  </u>		DATE SIGNED <u>9-24-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Sept 24, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Maurice G. Bernhart, F.H.</u>	22d. LOCATION (City, town, or county) (State) <u>Greensburg, Westmoreland, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McConnochie</u>		24. REC'D BY REGISTRAR <u>Sept 26, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Norma E. Moore</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 12 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 20 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, State Death Certificate

09577

9558

## CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Hartford.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>--</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>	
c. LENGTH OF STAY IN 1b <u>11.HRS.</u>		d. STREET ADDRESS <u>4919 St. Georges Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Wilson</u>		4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>Colored.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-13-57</u>
9. AGE (In years last birthday) yrs. <u>11</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Born</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John G. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John G. Wilson</u>		Address <u>4919 St. Georges Baltimore 13 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/13</u> , 19 <u>57</u> , to <u>9/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/13</u> , 19 <u>57</u> , and that death occurred at <u>6:55P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Stansbury</u> M.D.		ADDRESS (Street, city or town, state) <u>664 Revolution St., Harre-de-Grace, Md.</u>	
DATE SIGNED <u>9/13/57</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		<u>HARRE-DE GRACE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>9-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hartford Memorial Hospital</u>	22d. LOCATION (City, town, or county) (State) <u>Harre-de-Grace, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry A. Stansbury</u>		ADDRESS <u>Administrators</u>	
24a. REC'D BY REGISTRAR <u>9-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. H. Kinsio M.D.</u>	

RECEIVED  
SEP 20 1957  
BUREAU W. F.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9559

Reg. Dist. No.

0957881

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>31 Aberdeen</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>226 Paradise Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rudolph</b> Middle <b>Witlock</b> Last <b>Witlock</b>		4. DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Oct. 1899</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Wilmington, Del</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rudolph Witlock</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>705-07-1461</b>	
17. INFORMANT <b>Mrs. Hattie E. Witlock</b>		Address <b>226 Paradise Aberdeen, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of head of pancreas</b> <b>157x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>18 MONTHS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 10, 1956</b> , to <b>Sept 15, 1957</b> , that I last saw the deceased alive on <b>Sept 15, 1957</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. J. Plunkett Jr.</b>		ADDRESS (Street, city or town, state) <b>617 W. Bel Air Ave.</b>	
PHYSICIAN'S NAME (Type) <b>Barry J. Plunkett Jr. M.D.</b>		DATE SIGNED <b>Aberdeen, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/18/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wilmington Brook Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Wilmington, Del.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Lanning</b>		ADDRESS <b>Aberdeen, Md.</b>	
24a. REC'D BY REGISTRAR <b>Sept 17-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mellie R. Perry</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
Henderson		Male		25		1939	
Place of Birth		Race		Occupation		Cause of Death	
Missouri		White		Unknown		Unknown	
Usual Residence		Place of Death		Date of Death		Time of Death	
250 Levee Road		St. Louis, Mo.		10-10-67		10:00 AM	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 4

SEP 19 1967

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

Items 8,9 Film G223 11-29-57 et

09579

9575

## CERTIFICATE OF DEATH

Reg. Dist. No.

187

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>				c. LENGTH OF STAY IN 1b <u>1 yr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Lee</u> Last <u>Woody</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June, 8, 1870</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Woody</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Woody</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Lottie Jones, Fallston, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular disease</u> DUE TO (c) <u>with arterio sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>over 4 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>Sept 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 7</u> , 19 <u>57</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D. <u>307 Hickory</u>		ADDRESS (Street, city or town, state) <u>Bel Air Md.</u>		DATE SIGNED <u>Sept 9, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Philip W. Heuman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Sept. 9, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whitten Funeral Home</u>	22d. LOCATION (City, town, or county) (State) <u>Lynchburg, Lynchburg, Va.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward K. McComas Jr</u>		ADDRESS <u>Abingdon Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 11 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Marcella Lewis</u>		

# CERTIFICATE OF DEATH

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BUREAU V. S.

SEP 11 1967

RECEIVED